Medicaid Adjustment Request Form (ADJ-02)

Mail to: Adjustments
P. O. Box 241684
Montgomery, AL 36124-1684

Section I: Provider Pay-To Information

Provider Number: _____
Provider Name: _____
Address: _____
_____

Section II: Paid Claims Information
(Please enter data from your remittance advice)

ICN Number: _____
Recipient Number:_____
Recipient Name:_____
Date(s) of Service:_____
BilledAmount:_____
Paid Amount:_____

Section III:

Reason for Recoupment

_____Duplicate payment.
_____Claim billed in error.
_____Recoup/delete line item_____.
_____Billed under wrong Recipient.
_____Primary insurance payment received
_____Provider to rebill.
_____Medicare paid primary.
Other_____
_____

-or-

Reason for Adjustment

_____Change the number of units from ____ to ____ for procedure code_____.
_____Change the procedure code from _____ to _____ on line item_____.
_____Change the submitted charge from _____ to _____.
_____Change_____(place/date) of service from _____ to _____ on line item _____.
_____Add/delete modifier on line item_____.
_____Add/adjust primary insurance payment to _____.
_____Adjust coinsurance/deductible from _____ to _____.
_____Change the performing/provider number from _____ to _____.
_____Correct the diagnosis code from _____ to _____.
_____Re-release claim to pay at correct liability/provider rate.
Other _____
_____

Signature_____ Date_____ Telephone#_____